16. Adjunctive general services:

a. General anesthesia;

b. Hospital calls, services in hospitals;

17. Any other service not specified in this rule as a covered dental service or as a non-covered dental service.

(3) OTHER LIMITATIONS. (a) A full-mouth series of radiographs (including either a full-mouth intra-oral series of radiographs including bitewings, or a panographic film including bitewings, but not both) will be reimbursed only once per patient per dentist during a three-year period.

(b) Bitewing films will be reimbursed only once per patient per dentist during a six-month period.

(c) Prophylaxis procedures will be reimbursed only once during a six-month period per patient per dentist, unless prior authorized.

(d) Fluoride treatments—topical shall be reimbursed only once during a six-month period per patient per dentist, unless prior authorized.

(e) Training in preventive dental care shall be reimbursed only once per patient.

(f) Only one house call or nursing home call charge per day per home visited shall be reimbursed, regardless of the number of patients/residents seen at each home.

(g) Initial oral examinations shall be reimbursed only once during a one-year period per patient per dentist.

(h) Periodic oral examinations shall be reimbursed only once during a six-month period per patient per dentist.

(i) Requests for replacement of full or partial dentures shall be judged on an individual case basis according to the necessity and appropriateness of the prosthetic appliance. The department shall consider the following criteria when evaluating the request: medical necessity; appropriateness; extent to which less expensive alternative services are available; misutilization practices of recipients; and adequacy of information in the prior authorization request as presented by the provider.

(4) NON-COVERED SERVICES. Non-covered services are those listed below (in addition to those listed in section HSS 107.03 of this rule):

(a) Dental implants and transplants;

(b) Fluoride mouthrinse;

(c) Services for purely esthetic (cosmetic) purposes;

(d) Overlay dentures;

(e) Cu-sil dentures;

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.08 Hospital services. (1) COVERED SERVICES. (a) *Inpatient hospital services.* Covered inpatient hospital services are those medically necessary services ordinarily furnished by the hospital, for the care and treatment of inpatients, which are provided under the direction of a physician or dentist in an institution which is a certified provider.

(b) *Outpatient hospital services.* Covered hospital outpatient services are those preventive, diagnostic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient in a hospital which is a certified provider.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION.

Note: For more information on prior authorization, see subsection 7.02(3).

The following covered services require prior authorization:

(a) Covered hospital services if provided out-of-state under non-emergency circumstances by non-border status providers.

(b) Hospitalization for non-emergency dental services.

(c) Hospitalization for any surgical procedure noted in section HSS 107.06(2) of this rule.

(3) OTHER LIMITATIONS. (a) Inpatient admission for non-therapeutic sterilization is a covered service only if the procedures specified in section HSS 107.06(2) (zk) of this rule are followed;

(b) Private room accommodations are covered services when the recipient has one or more of the following diagnoses:

Abscess
Acute upper respiratory infection
Acute viral infection
Agammaglobulinemia
Anthrax
Aszhemer's Disease
Bronchitis
Burns—third degree
Ceasarian Section
Cellulitis
Cerebral Concussion
Cholera
Conjunctivitis, Inclusive
Diabetic Kioacidosis
Diarrhea Enteropathic (E. coli.)
Diptheria
Down's Syndrome
Epigottitis
Gas gangrene (due to Costridium perfringens)
Gastroenteritis (due to Salmonella, Shigella or E. coli.)
Gonococcal Opthalmia Neonatorum
Herpes Simplex & Disseminated neonatal
Herpes Zoster
Infectious Hepatitis
Laryngotracheobronchitis
Lassa Fever, Marburg virus disease
Leukemia
Listerosis
Measles
Melioidosis, extrapulmonary
Meningitis, Aseptic
Menigitis, Meningoccoccal
Mental Retardation listed with any diagnosis
Mononucleosis
Mumps
Narcotic Addiction
Otitis Media Pharyngitis
Overdose
Peritonitis
Pertussis
Plague, Pneumonic or Bubonic
Poliomyelitis
Pneumonia with Staphlococcus or streptococcus
Pregnancy with an infectious diagnosis
Pregnancy, pre-eclampsia

OFFICIAL 12.

(4) NON-COVERED SERVICES. The following services are not covered (in addition to those listed in HSS 107.03 of this rule):

(a) Services of private duty nurses when provided in a nursing home.

(b) For Christian Science sanitoria, custodial care and rest and study.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

12.a HSS 107.10 Drugs. (1) COVERED SERVICES. Drugs and drug products covered by the medical assistance program include legend and certain non-legend drugs and supplies prescribed by a physician licensed pursuant to s. 448.04, Stats., by a dentist licensed pursuant to s. 447.05, Stats., or by a podiatrist licensed pursuant to s. 448.04, Stats. The department may determine whether or not drugs judged by the food and drug administration to be "possibly effective" shall be reimbursable under the program.

(2) SERVICE REQUIRING PRIOR AUTHORIZATION.

Note: For more information on prior authorization see HSS 107.02(3.)

The following drugs/supplies require prior authorization:

(a) All CS II stimulant drugs.

(b) Stimulant drugs in CS III and CS IV with the exception of Ritalin, Sanorex, Deaner and including salts and/or derivatives of Phentermine, Chlorphentermine, Fenfluramine, Phendimetrazine, Diethylpropion, Pipradrol Benzphetamine (alone or combination).

(c) Methaqualone.

(d) All high nitrogen food supplement/replacement products; Lytren, Ensure, Polycose, etc.

(e) Debrisan.

(f) Derifil.

(3) OTHER LIMITATIONS. (a) Dispensing of schedule III, IV and V drugs shall be limited to the original dispensing plus 5 refills, or 6 months, whichever comes first.

(b) Dispensing of non-scheduled legend drugs shall be limited to the original dispensing plus eleven refills, or 12 months, whichever comes first.

(c) Generically-written prescriptions are required to be filled with a generic drug included in the Wisconsin drug formulary.

(d) Legend drugs, except drugs dispensed by unit-dose methods, shall be dispensed in amounts not to exceed a 34-day supply.

(e) Provision of drugs and supplies to nursing home recipients shall comply with the department's policy on ancillary costs as specified in HSS 107.09(3).

(f) To be included as a covered service, an over-the-counter drug shall be: used in the treatment of a diagnosable condition; and a rational part of an accepted medical treatment plan. Only the following generic categories of over-the-counter drugs are covered:

13.

OFFICIAL

1. Laxatives.

2. Antacids.

3. Analgesics.

4. Insulins.

5. Minerals and vitamins.

6. Antibiotics—Topical.

7. Antidiarrheals.

8. Hemorrhoidal products.

9. Certain cold and allergy products (e.g., nasal sprays, cough syrups, etc.).

10. Asthma products.

11. Contraceptives.

12. Ophthalmic products (e.g., eye washes, artificial tears).

(4) NON-COVERED SERVICES. The following are not covered services:

(a) Claims for underpads or chux for nursing home recipients when billed by a pharmacy provider.

(b) Refills of schedule II drugs.

(c) Refills beyond the limitations of sub. (3).

(d) Personal care items (e.g. non-therapeutic bath oils).

(e) Cosmetics (e.g. non-therapeutic skin lotions, sun screens).

(f) Common medicine chest items (e.g. antisepticcs, bandaids).

(g) Personal hygiene items (e.g. tooth paste, cotton balls).

(h) "Patent" medicines.

(i) Uneconomically small package sizes.

(j) Items which are in the inventory of a nursing home regardless of the person's residing in the home.

(k) Over-the-counter drugs not specified in the Drug Index and not included in the categories in subsection (3) above, and legend drugs not included in the Drug Index maintained by the department.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.11 Nursing, home health care, and personal care services. (1) COVERED SERVICES. (a) Services provided by an agency certified under HSS 105.16. Services provided by an agency certified under HSS 105.16 which are covered by the medical assistance program are part-time or intermittent nursing, home health aide, and personal care services, medical supplies, equipment and appliances suitable for use in the home, and therapeutic services which the agency is certified to provide, when provided upon prescription of a licensed physician to a recipient confined to a place of residence. Such residence does not include a

to acceptable clinical and administrative record-keeping before any service is provided. The registered nurse shall document the care and services provided and shall make such documentation available to the department upon request.

(c) Private duty nursing services may only be provided when the recipient requires individual and continuous care beyond that available on a part-time or intermittent basis, and when the recipient's physician has prescribed private duty nursing.

(d) Personal care services may be provided only after an evaluation based on a functional assessment scale provided by the department, pursuant to HSS 105.16 (8) (c) 1.

(e) Personal care services shall be reported and billed as a separate service on Medicaid claim forms provided by the department.

(f) The registered nurse shall reevaluate the recipient's condition not less frequently than every 60 days. The reevaluation shall include at least one visit to the recipient's home, a review of the personal care worker's daily written record, a review of the plan of care and contact with the physician as necessary. If a change in level of care is necessary, appropriate referrals shall be made.

(g) Persons providing and supervising personal care services shall be adequately trained and oriented to the provision of care in the home. In the case of the personal care worker, this means a minimum of 40 hours of training. In the case of the registered nurse supervisor, this means an orientation session with the public health nurse, except if the registered nurse is a public health nurse or has had experience providing nursing services in a patient's home.

(4) NON-COVERED SERVICES.

(a) Private duty nursing services provided in a nursing home are not covered by the medical assistance program.

(b) Medical social services are not a covered service.

(c) Christian Science nursing services are not covered.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.13 Mental health services. (1) INPATIENT PSYCHIATRIC SERVICES. (a) *Covered services.* Inpatient psychiatric care is a covered service when prescribed by a physician, and when provided within a psychiatric unit of a general hospital which meets the requirements of HSS 105.09, or when provided by a JCAH-accredited psychiatric facility within the limitations enumerated below.

(b) *Requirements for coverage of inpatient psychiatric facility services for recipients under 21 years of age.*

1. Inpatient psychiatric services for recipients under age 21 must be provided under the direction of a physician; and by a psychiatric facility or an inpatient program in a psychiatric facility, either of which is accredited by the joint commission on accreditation of hospitals; and before the recipient reaches age 21 or, if the recipient was receiving the services immediately before reaching age 21, before the earlier of the following:

a. The date the recipient no longer requires the services; or

b. The date the recipient reaches age 22.

2. Certification of need for services. A team specified in HSS 107.13 (1) (b) 3. must certify that:

a. Ambulatory care resources available in the community do not meet the treatment needs of the recipient; and

b. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

c. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

d. The certification specified in this section and in HSS 107.13 (1) (b) 3. satisfies the utilization control requirement for physician certification in HSS 107.13 (1) (b) 7.

3. Team certifying need for services. Certification under HSS 107.13 (1) (b) 2. must be made by teams specified as follows:

a. For an individual who is recipient when admitted to a facility or program, certification must be made by an independent team that includes a physician; has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and has knowledge of the individual's situation.

b. For an individual who applies for medicaid while in the facility or program, the certification must be made by the team responsible for the plan of care and specified in HSS 107.13 (1) (b) 6.; and cover any period before application for which claims are made.

c. For emergency admissions, the certification must be made by the team responsible for the plan of care within 14 days after admission.

4. Active treatment. Inpatient psychiatric services must involve "active treatment," which means implementation of a professionally developed and supervised individual plan of care, described in HSS 107.13 (1) (b) 5. that is:

a. Developed and implemented no later than 14 days after admission; and

b. Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

5. *Individual plan of care.*

a. "Individual plan of care" means a written plan developed for each recipient in accordance with HSS 107.13 (1) (b) 9. and 10., to improve his condition to the extent that inpatient care is no longer necessary. The plan of care must:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;

2. Be developed by a team of professionals specified under HSS 107.13(1)(b)6. in consultation with the recipient; and his parents, legal guardians, or others in whose care he will be released after discharge;

3. Specify treatment objectives;

4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and

5. Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge.

b. The plan must be reviewed every 30 days by the team specified in HSS 107.13(1)(b)6. to:

1. Determine that services being provided are or were required on an inpatient basis, and

2. Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

c. The development and review of the plan of care as specified in this section satisfies the utilization control requirements for:

1. Physician certification; and

2. Establishment and periodic review of the plan of care.

6. *Team developing individual plan of care.*

a. The individual plan of care must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in, the facility.

b. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of:

1. Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

2. Assessing the potential resources of the recipient's family;

3. Setting treatment objectives; and

4. Prescribing therapeutic modalities to achieve the plan's objectives.

c. The team must include, as a minimum, either:

1. A Board-eligible or Board-certified psychiatrist;

2. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

3. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

d. The team must also include one of the following:

1. A psychiatric social worker.

2. A registered nurse with specialized training or one year's experience in treating mentally ill individuals.

3. An occupational therapist who is licensed, if required by the state, and who has specialized training or one year of experience in treating mentally ill individuals.

4. A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

7. *Physician certification and recertification of need for inpatient care.*

a. A physician must certify and recertify for each applicant or recipient that inpatient services in a mental hospital are or were needed.

b. The certification must be made at the time of admission or, if an individual applies for assistance while in a mental hospital, before the medicaid agency authorizes payment.

c. Recertification must be made at least every 60 days after certification.

8. *Medical, psychiatric, and social evaluations.*

a. Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each applicant's or recipient's need for care in the hospital; and appropriate professional personnel must make a psychiatric and social evaluation.

b. Each medical evaluation must include diagnoses; summary of present medical findings; medical history; mental and physical functional capacity; prognoses; and a recommendation by a physician concerning admission to the mental hospital; or continued care in the mental hospital for individuals who apply for medicaid while in the mental hospital.

9. *Individual written plan of care.*

a. Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each applicant or recipient. The plan of care must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

2. A description of the functional level of the individual:

3. Objectives;

4. Any orders for medications; treatments; restorative and rehabilitative services; activities; therapies; social services; diet; and special procedures recommended for the health and safety of the patient;

5. Plans for continuing care, including review and modification to the plan of care; and

6. Plans for discharge.

7. The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 90 days.

b. Before admission to a SNF or before authorization for payment, the attending physician must establish a written plan of care for each applicant or recipient in a SNF. The plan of care must include:

1. Diagnoses, symptoms, complaints and complications indicating the need for admission;

2. A description of the functional level of the individual;

3. Objectives;

4. Any orders for medications; treatments; restorative and rehabilitative services; activities; therapies; social services; diet; and special procedures recommended for the health and safety of the patient;

5. Plans for continuing care, including review and modification to the plan of care; and

6. Plans for discharge.

7. The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 60 days.

10. *Reports of evaluation and plans of care.* A written report of each evaluation and plan of care must be entered in the applicant's or recipient's record:

a. At the time of admission; or

b. If the individual is already in the facility, immediately upon completion of the evaluation or plan.

11. Recipients under age 22 residing in JCAH-accredited inpatient psychiatric facilities, and recipients over age 65 residing in an institution for mental diseases are eligible for medicaid benefits for services not provided though that institution and not reimbursed as part of the cost of care of that individual in the institution.

12. *Patient's accounts.* Each recipient who is a patient in a state, county, or private mental hospital shall have an account established for the maintenance of earned or unearned money payments received (Social Security payments, SSI payments, etc.). The account for patients in state mental health institutes shall be kept in accord with section 46.07, Wis. Stats. The payee for the account may be the recipient, if competent, or a legal representative.

a. Legal representatives who are employees of county departments of social services or the department of health and social services shall not receive payments.

b. If the payee of the resident's account is a relative, friend or other legal representative, the payee shall submit an annual report on the account to the Social Security Administration.

(c) *Other Limitations—Inpatient psychiatric services.*

1. Diagnostic interviews with immediate family members of the recipient are covered services. Immediate family members means parents, spouse or children or for a child in a foster home, foster parents. A maximum of 5 hours of such interviews shall be covered.

2. Psychotherapy is a covered service when provided to inpatients for whom the therapy is prescribed as a component of the plan of care.

(d) *Non-Covered Services—Inpatient psychiatric services.* 1. Activities which are primarily diversional in nature such as services which act as a social or recreational outlet for the recipient are not covered services.

2. Mild tranquilizers or sedatives provided solely for the purpose of relieving anxiety or insomnia are not covered services for inpatients in a psychiatric facility.

3. Consultation with other providers about the recipient's care is not a covered service.

4. Inpatient psychiatric hospital services are not covered for recipients who are between the ages of 22 and 65.

(2) OUTPATIENT PSYCHOTHERAPY SERVICES. (a) *Covered services.* Outpatient psychotherapy services are covered services when prescribed by a physician and when provided by a provider who meets the requirements of section HSS 105.22, and when the following conditions are met:

1. The psychotherapy furnished is in accordance with the definition of psychotherapy in chapter one of this rule.

2. A differential diagnostic examination is performed by a certified psychotherapy provider. A physician's prescription is not necessary to perform the examination.

3. Before the actual provision of psychotherapy services, a physician shall prescribe therapy in writing.

4. Psychotherapy is furnished by a:

a. Provider who is a licensed physician or a licensed psychologist defined under HSS 105.22(1) (a) or (b), and who is:

i. Working in an outpatient facility defined under HSS 105.22(1) (c) (d) or (e) which is certified to participate in the medical assistance program, or

ii. Working in private practice; or

b. Provider defined under HSS 105.22(2) (a) (1), (2) or (3) who is:

i. Working in an outpatient facility defined in HSS 105.22(1) (c) (d) or (e) which is certified to participate in the medical assistance program.

5. Psychotherapy is performed only in the following locations:

a. Office of the provider.

b. Hospital.